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Presenting...

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Meet our authors....

Father John C. Ford, S.J., author and lecturer, is at present professor of moral and pastoral theology at Weston College, Weston, Massachusetts. In addition to his doctorate in sacred theology taken at the Gregorian University in Rome where he taught for a brief period, Father Ford has received the degree of bachelor of laws for which he studied at Boston College. At the Boston College Law School he has taught jurisprudence and domestic relations and each year is a guest lecturer at the Yale School of Alcohol Studies. He has been a member of the Governor's Commission on Alcoholism in Massachusetts.

A new book of Father Ford's *Man Takes a Drink,* published by P. J. Kenedy Sons, New York ($2.50) comes from the press as we announce this to you. To quote a portion of the foreword written by the executive director of the National Committee on Alcoholism, "This book is desperately needed, for it tackles effectively and objectively, and with forthright clarity, one of the most baffling problems of modern life: the use of beverage alcohol." LINACRE QUARTERLY readers should read and recommend *Man Takes a Drink* to those who come to them for help with difficulties of this nature.

Dr. Laforet graduated from Boston College, Chestnut Hill, Massachusetts in 1944 and from Tufts College Medical School, Boston, Massachusetts in 1947. He is currently resident in surgery at Massachusetts Memorial Hospital and assistant in surgery at Boston University School of Medicine.

Father Casey, a priest of the Archdiocese of Boston, attended the College of the Holy Cross, Worcester, Massachusetts, and St. John's Seminary, Brighton, Massachusetts. At present, he is studying for his doctorate in ecclesiastical history at the Pontifical Gregorian University in Rome.

Mr. Francis X. Curley, S.J., preparing for the priesthood at Weston College, Weston, Massachusetts, the major seminary for Jesuits of the New England Province, contributes articles and poetry to the *Catholic World, America, Homiletic and Pastoral Review, American Ecclesiastical Review,* and others. It is hoped that his first effort for LINACRE QUARTERLY will be an introduction to more.

Father John J. Lynch, S.J., a frequent and valued contributor to our journal, is professor of moral and pastoral theology at Weston College. He received his M.A. and licentiates in philosophy and theology at Weston and doctorate in theology at Gregorian University in Rome. Father Lynch has also taught courses in moral theology and ethics at Boston College, Emmanuel College, Fordham University and Seattle University.

The Refusal of Blood Transfusions by Jehovah's Witnesses

by JOHN C. FORD, S.J.

JEHOVAH'S WITNESSES generally refuse to take blood transfusions even when these are judged by physicians to be absolutely necessary for the preservation of life and health. They believe that taking such transfusions is "eating blood," contrary to the prohibition of Leviticus, 3:17, and Acts, 15:29. Furthermore, Witnesses who are parents of young children often refuse to allow the children to be given blood transfusions under any circumstances. And Witnesses sometimes stipulate, before undergoing an operation or delivery, that they will not consent to a blood transfusion for any reason whatever.

This attitude raises various questions: first, as to the Scriptural basis of their beliefs; second, as to the moral obligations of the parties concerned; third, as to the legal liability of physicians and hospitals; and fourth, as to the public policy which should be formulated for handling this type of problem.

I. SCRIPTURAL BASIS

Jehovah's Witnesses base their practice on a Biblical prohibition against eating blood. Leviticus 3:17 reads: "By a perpetual law for your generation, and all your habitations, neither blood nor fat shall you eat at all." (Cf. also Leviticus, 7:26-27; 17:10-14; 19:26.) It is the position of the Witnesses that a blood transfusion violates this law of Jehovah.[1]

If it is objected that this was a *dietary* law, having nothing to do with the medical use of blood, they reply that a transfusion is the equivalent of eating; it is intravenous feeding. If it is objected that the Biblical prohibition had to do with *animal* blood, they reply that since the prohibition is based on the sacred, life-giving character of the blood, it applies *a fortiori* to human blood. If it is objected that the law also forbade fat, they say that that part of the law ceased with the New Testament, while the law against blood did not.

For they do not admit that the Biblical prohibition of blood was merely a Mosaic law. They say that this particular law antedated Moses by centuries, citing Genesis 9:4; and that it was enforced anew in New Testament times, citing Acts, 15:29. This is the famous passage which records the decision of the Council of Jerusalem, given for certain new Christian converts among the Gentiles: "That you abstain from things sac-

[1] *The Watchtower*, 72 (July 1, 1951) n. 13 pp. 414-416, published at Jehovah's Witnesses' headquarters in Brooklyn, gives a rather complete exposition of the Witnesses' teaching about blood transfusions.

rificed to idols, and from blood, and from things strangled, and from fornication. . . ."

Whatever may have been the meaning of the decree of the Council of Jerusalem, and whatever its force (there are uncertainties on both points), it is clear from the whole history of Christendom that the eating of blood is no longer forbidden. From very early times the whole Church has proceeded on the assumption that this law was abrogated with the coming of the Gospel. It is futile to cite a New Testament passage of uncertain meaning in the face of this universal tradition.

Exegetes take two general courses in explaining the passage from Acts, 15:29. Most of them admit that the decree was concerned with dietary law, but hold that it was a temporary, local ordinance.[2] They point out that it was addressed to the brethren of Gentile origin in Antioch, Syria and Cilicia (Acts, 15:23), and that its motivation was to avoid shocking the Jewish converts who had been brought up for generations in the Mosaic tradition (Acts, 15: 19-21). This view is confirmed by the practice of St. Paul, who, though present at the Council, and one of the messengers sent to announce the decision, did not enforce it himself a few years later in another part of the world. Writing to the Corinthians a few years after the Council of Jerusalem he gives a decision permitting one of the things the decree had forbidden, namely the eating of meat offered to idols (1 Corinthians, 10: 25-30). If one of these dietary prohibitions was not of universal obligation, then it is improper to urge that the others were.

Another explanation, followed by a few, is based on a good, early manuscript which omits the prohibition against "things strangled." If this is omitted, then the other three prohibitions bear a meaning which is not dietary at all. They would refer to the three great sins of idolatry, murder and impurity. The prohibition of blood would merely be a prohibition of murder. These interpreters believe that moral precepts harmonize better with all the circumstances than mere dietary laws.[3]

Whatever the meaning and force of the decree, the thing that is clear from tradition and from the teaching of the Church is that there is no longer any law of God that forbids "eating blood." The Scriptural interpretations of the Jehovah's Witnesses suffer not only from a lack of general principles of scholarly exegesis, but also from the fundamental defect of looking to the Bible as if it were a guide in a vacuum, independent of the teaching of the Church, and independent of the whole history of Christian tradition. Christendom did not have to await the coming of the Witnesses to learn that "eating blood" has been forbidden to Christians all along. And if it had been, it would still be a long jump

[2] Cf. E. B. Allo, O.P., *Première Épitre aux Corinthiens*, (Paris, 1934) p. 247.

[3] Cf. *Expository Times*, 41 (Dec., 1929) pp. 128-129; and Westminster Version, III, p. 221 n. The shorter text is favored by Allo with Harnack. Cf. Allo, *op. cit.*, p. 196.

to conclude that to take a blood transfusion is to "eat blood."[4]

II. MORAL QUESTIONS

Is a blood transfusion an ordinary means of preserving life and health?

The terms *ordinary* and *extraordinary* do not always mean the same thing to doctors and theologians. Sometimes a procedure which any physician would call ordinary would be considered extraordinary in the theological sense.[5] There is no doubt that a blood transfusion is an ordinary means of preserving life and health as far as the physician is concerned. And it would seem, nowadays, that in most circumstances, a blood transfusion would be considered an ordinary means in the theological sense. At least in cities, where hospital care and transfusions are easily available and not unduly expensive, I believe most theologians would call it an ordinary means of preserving life and health. The moral consequence is that given these circumstances a patient would be obliged to take this means when it is judged necessary to preserve life.

But is a blood transfusion an ordinary means for a person who is firmly convinced on religious grounds that such a transfusion is an offense against the law of God? This raises the question as to how far one may take into account subjective feelings, subjective errors, mistaken attitudes, etc., in estimating what is ordinary and what is extraordinary, and in deciding the consequent objective obligation to take given affirmative measures to preserve life; or in deciding the objective liceity of foregoing such measures.

At first sight it may seem strange that subjective errors and attitudes can be the determinants of objective morality. A little reflection, however, will show that it has been customary with moralists to allow subjective elements to be taken into account in making the moral judgment as to what is ordinary or extraordinary in a given case. In the last analysis this may rest on the concept of stewardship. It is because we are stewards, acting in the name of God, that we are obliged to take ordinary care of our health. There is nothing contradictory in supposing that God does not demand of a steward efforts which for him are extraordinary, even if it is an erroneous idea of the steward that makes them so.

For instance, all are agreed that the individual circumstances must be taken into account, and one of the circumstances is the amount of pain involved in a given procedure. But pain is a highly subjective

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[4] Witnesses would presumably object to blood plasma just as they do to whole blood. I do not know if they would object to a synthetic plasma substitute like "Gentran." Many serums and antitoxins are made from blood. Logically, it would seem they should refuse all of these, also.

[5] Cf. J. C. Ford, S.J., and J. E. Drew, M.D., "Advising Radical Surgery: A Problem in Medical Morality," *Journal of the American Medical Association,* 151 (Feb. 28, 1953) pp. 711-716. For a general discussion of ordinary and extraordinary means see G. Kelly, S.J., "The Duty of Using Artificial Means to Preserve Life," *Theological Studies,* 11 (June 1950) n. 2, pp. 203-220; and "The Duty to Preserve Life," *ibid.,* 12 (Dec. 1951) n. 4, pp. 550-556.

phenomenon. Some people can stand a good deal. Others cannot. They have an exaggerated horror or an exaggerated reaction even to a small amount of pain. This is one subjective, variable element which all moralists, I believe, would recognize as having to be taken into account to decide the objective obligation.[6]

Some moralists also give the example of a groundless or exaggerated fear of surgical operations of any kind. They admit that in such cases an ordinary surgical procedure can be considered extraordinary for the individual in question.[7]

Authors also recognize that a woman who has an extreme (and therefore irrational) horror of being examined by a physician, cannot be accused of sin if she refuses to take this otherwise ordinary means to preserve life and health. For her it is extraordinary, because of her subjective misconception as to what the virtue of chastity demands, or her subjective emotional horror which is in fact altogether unreasonable.[8]

Finally there is the well-known, if somewhat fanciful, example of the dying Carthusian who will eat no meat even if the doctors consider it necessary to preserve his life and health. The Carthusian does this, in the supposition, out of love of his Rule. But he has a mistaken idea as to what the Rule requires. Yet authors admit that his mistaken or exaggerated ideas of devotion to the Rule make the use of this ordinary means extraordinary for him.[9]

From all this, I would conclude that subjective elements and mistaken subjective attitudes may sometimes be taken into account when deciding the objective obligation to make use of a given procedure.

With a sincere Jehovah's Witness who is firmly convinced that a transfusion offends God, we are dealing with a case where his conscience absolutely forbids him to allow the procedure. In this mistaken frame of mind he would actually commit sin if he went against his conscience and took the transfusion. I see no inconsistency in admitting that this frame of mind is a circumstance which makes the transfusion for him an *extraordinary* means of preserving life. And it does not seem contradictory to me to admit that while his reason for refusing is objectively mistaken and groundless, nevertheless his frame of mind can become at the same time an objective excuse from the moral obligation which would otherwise be present. The obligation to take positive measures to preserve life is an affirmative one, and it is not unreasonable to suppose that God, who is the master of life and death, does not objectively require of his steward a means of self-preservation which appears to the steward to be certainly sinful. In coming to this tentative conclusion, I am influenced also by the thought that we can allow an individual consider-

[6] Noldin, *De Praeceptis*, n. 325, 3, a.
[7] Genicot, *Theologia Moralis*, I, n. 364; Noldin, *op. cit.*, n. 325, 3, b, citing Capellmann-Bergmann.
[8] St. Alphonsus, *Theologia Moralis*, lib. III, n. 372, cited by many others.
[9] Vermeersch, Theologia Moralis, II, n. 300, 5.

able leeway in exposing his own life to danger, especially in the negative way of not taking surgical means to preserve it, and also by the thought that it is always easier to consider a procedure objectively extraordinary when it is artificial, comparatively recent, and technically rather complicated.

The consequence of this opinion for the physician is obvious. Where the patient is not morally obliged, objectively, to make use of a procedure, and actually refuses it, the physician is not morally obliged to give it to him; nor do the hospital administrators have a moral obligation to see that he gets it.

In fact, even if one holds that the Witness has an objective obligation to take the transfusion, it will not in practice make much difference in estimating the personal moral obligation of the physician or hospital administrator. If a person had the erroneous religious belief that he should commit suicide by taking positive means to kill himself, we would all agree that it would be justifiable and usually obligatory to prevent him by force from doing so. But when the erroneous belief has to do with the omission of a positive, artificial means of self-preservation, it is an entirely different matter to assert that the physician has any right, and much less any duty, to force a patient to conform to the objective moral law. Naturally all concerned (no matter what theory they hold as to the objective or subjective morality of the case) will try to persuade the patient to be sensible. But failing to do so, I do not see that there is any further moral obligation, in either theory, to take action. The question of legal liability will be discussed below.

Another consequence of the view that the sincere Witness is not objectively obliged to have a transfusion is this: From the moral point of view, as far as his individual relationship with the patient is concerned, the physician would be more readily justified in making an agreement not to give him a transfusion. But it is a different matter to decide whether a physician would be morally justified in making such an agreement in view of the legal consequences which the observance of the agreement might entail for himself and for the hospital where he practices. It seems to me that it is both unwise and unjustifiable for a physician or a hospital to make an agreement involving serious risks of this kind. A word will be said about legal liability below.

When a physician makes an agreement not to give a transfusion he is obliged *per se* to honor it. Sometimes, however, contractual agreements cease to bind when unforeseen events make a substantial change in the subject matter or the circumstances of the agreement. For instance, a physician might agree to give no transfusion, and later discover, with the patient at death's door, e.g. from hemorrhage during Cesarean section, that observance of it would entail serious legal consequences for himself and for the hospital where he is working. Such unforeseen circumstances would, in my opinion, be sufficient grounds for releasing him from his moral obligation to

go through with the agreement. Furthermore, if the law were to void an agreement of this kind as being contrary to public policy, this might well constitute grounds for a release from one's personal obligation to observe it, even if it were not clear whether the law invalidated the contract itself for the forum of conscience from the beginning.

The foregoing opinions have to do with the case of an adult Witness. The practical problems are more difficult and delicate when the patient is a child or a baby, and the parents' religious convictions lead them to refuse to allow a necessary transfusion to be given. Acute cases have arisen involving children and infants who are in desperate need of transfusion.[10] The rights and duties of all concerned are very different in these cases from the case of the adult Witness.

It is clear that a child has an objective right to ordinary care, no matter what its parents' mistaken beliefs may be. Consequently, when a blood transfusion is a necessary part of this ordinary care, the parents have an objective moral obligation to supply it, and if they fail to do so, others who have undertaken the care of the child, such as physicians and hospital authorities, have *per se* a moral obligation to see that the child gets it. In the case of a young child, therefore, it would be morally wrong to make an agreement not to administer a transfusion in case of serious need; and if such an agreement were made, one would have no obligation to honor it.

The obligation of physicians and others who have actually undertaken to care for the child would ordinarily be an obligation of justice as well as of charity. Others who have not actually undertaken the care of the child might have an obligation of charity to intervene in order to see to it that a neglected child is properly cared for.

When serious bodily harm to the child, or even its life is at stake, no one will concede that the parents' erroneous religious beliefs must be respected; they have no right to inflict them on their children.

When there is question of taking means to preserve life, we can allow a person a degree of control where his own life is concerned, but can without inconsistency refuse him such power where another's life is at stake. For instance, a theologian who would permit a Carthusian to refuse meat and continue his abstinence even though it endangered his life, would never conceivably permit a Carthusian superior, out of love of the Rule and in order to strengthen religious discipline, to impose abstinence on such a subject, or refuse to give him meat when the doctor ordered it. A parent whose false ideas of chastity or horror of physical examination might be considered a valid reason or sufficient excuse for refusing medical care herself, would never be allowed by any moralist to inflict these ideas on her young child. If she refused to allow the doctor to make a neces-

[10] Cf. C. C. Cawley, "Parens Patriae: The Sovereign Power of Guardianship," *New England Journal of Medicine*, 251 (Nov. 25, 1954) n. 22, pp. 894-897.

sary examination of her child for such a reason she would simply be accused of sinful neglect by the moralists. Likewise a religious superior, extraordinarily sensitive to pain, though he might himself be excused from undergoing a painful operation of an ordinary kind, could not possibly be permitted to inflict his ideas on a religious subject. Furthermore, one might legitimately risk one's own life and be a martyr of bravery, but one could not oblige another to do the same in the same circumstances. And so it is possible, without inconsistency, to admit that a blood transfusion may be an extraordinary means for one who is erroneously convinced in his personal conscience that such a transfusion offends God; but to deny that anyone, even a parent, has a right to inflict such erroneous ideas on a child.

There are limits to the power of disposal which parents have over the bodies of their children. They cannot do them bodily injury and they cannot refuse them ordinary medical care. The Catholic position, based on natural law, would be in accord with those legal decisions which oblige parents to conform to an objective standard of ordinary care.

It is difficult to define with any accuracy what is meant by a young child. Certainly one who has reached his legal majority is able to speak for himself if he is normally *sui compos*. Certainly one who has not reached the age of reason cannot speak for himself. But what about those who are, for example, between the ages of seven and twenty-one? Hardly anyone would say that a nine-year-old-child could decide for himself to refuse the transfusion even at the risk of life. But there might be many a nineteen-year-old that could. No one can draw the age line exactly, and it would always be subject to individual differences, because some children attain maturity earlier than others. But the younger the child, the more one would hesitate to allow it to make such a decision. And of course, the physician should take special legal precautions to protect himself in the case of any minor.

It was stated above that physicians and others who have undertaken the care of a child have *per se* a moral obligation to administer a transfusion when this is an ordinary and necessary means of preserving life; and that the mistaken religious beliefs of the parents do not of themselves excuse from this obligation. The phrase *per se* was used because in practice the physician may not be able, morally speaking, to do what he believes is necessary. If he insists on a transfusion, the parents will probably take him off the case. Or if they persist in their refusal, he could be morally justified in withdrawing from the case. After all his legal position is far from clear; and it is no small matter to undertake a surgical procedure on a young child contrary to the express refusal of the parents to allow it. Serious surgical accidents happen even with a relatively safe procedure like a blood transfusion. Where would the physician stand if such an accident happened when he was operating contrary to the

parents' will? The moral consequence of these considerations is that although there is *per se* an obligation to administer such a transfusion, there may often be an excuse from it in practice—at least in those cases where physicians and hospital administrators are not protected by a court order.

N.B. Part III on LEGAL LIABILITY and Part IV on PUBLIC POLICY will follow in the next issue of LINACRE QUARTERLY.

"THE OLDEST medical manuscript in Ireland appears to be one copied in 1352. The Irish mss. of the 13th-18th century, preserved in the libraries of Dublin, London, and Oxford form a collection of medical literature which is probably the largest in existence in any one tongue. There are eighty of these medical mss., some of which have been published in the Royal Irish Academy, Dublin.

The preface to the ms. of 1352 breathes a spirit worthy of the best traditions of the medical faculty: 'May the merciful God have mercy on us all. I have here collected practical rules from several works, for the honor of God, for the benefit of the Irish people, for the instruction of my pupils, and for the love of my friends and of my kindred. I have translated them from latin into gaelic from the authority of Galen in the last book of his *Practical Pantheon,* and from the *Book of the Prognostics of Hippocrates* . . . I pray God to bless those doctors who will use this book; and I lay it on their souls as an injunction, that they extract not sparingly from it; that they fail not on account of neglecting the practical rules (herein contained); and more especially that they do their duty devotedly in cases where they receive no pay (on account of the poverty of the patients). I implore every doctor that before he begins his treatment he remember God, the Father of health, to the end that his work may be finished prosperously. Moreover, let him not be in mortal sin, and let him implore the patient to be also free from grievous sin. Let him offer up a secret prayer for the sick person, and implore the Heavenly Father, the Physician and Balm-giver for all mankind, to prosper the work he is entering upon and to save him from the shame and discredit of failure.' "

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Medical Aspects of the Holy Eucharist:

A Physiological and Canonical Study

by Eugene G. Laforet, M.D.
and Rev. Thomas F. Casey

In no other Sacrament is Divinity so intimately perfused in material substance as in the Holy Eucharist, and in no other Sacrament is the union of the recipient with his Creator physical as well as spiritual. The physical and especially the physiological aspects of this Sacrament render it of unique importance to the physician. The object of this paper is briefly to summarize medically pertinent canonical regulations related to the Sacrament and to examine experimental data concerning time-relationships of the human digestive process.

The practical aspect of the reception of Holy Eucharist by a patient often presents multiple facets to the physician. The patient may require an indwelling Levin tube with constant Wangensteen-type suction. Vomiting may be intractable. Death may be imminent. Severe diarrhea may supervene in a patient with an ileostomy. In addition, the performance of an autopsy upon a person who has recently received Viaticum poses further related questions. In general, theological opinion holds that the Divine Presence remains as long as the physical form of the host is incorrupt "according to common estimation." The crux of the problems suggested above lies in the time required for physiological alteration ("corruption") of the host by the human digestive system.

Generally speaking, alteration or "corruption" of the ingested wafer (starch) is dependent upon both mechanical and chemical factors. Deglutition and gastric peristalsis contribute to the physical disruption of the host. Chemical or enzymatic degradation proceeds *pari passu* due to the action of the salivary enzyme, ptyalin. Salivary digestion is influenced by (a) the amount of ptyalin in the saliva, (b) the thoroughness of mechanical mixture of ptyalin and substrate, and (c) the time during which the enzyme is allowed to act.[1] Since the optimal pH for ptyalin activity is in the range 6.6 - 6.8, it is evident that high gastric acidity may effectively neutralize its amylolytic action.

In an effort to estimate the approximate time required for corruption of the host under varying conditions, a series of fifty *in vitro* experiments was conducted.

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[1] Bard, P. (ed.): Macleod's Physiology in Modern Medicine, 9th ed., St. Louis, The C. V. Mosby Company, 1941. p. 964.

TABLE I.

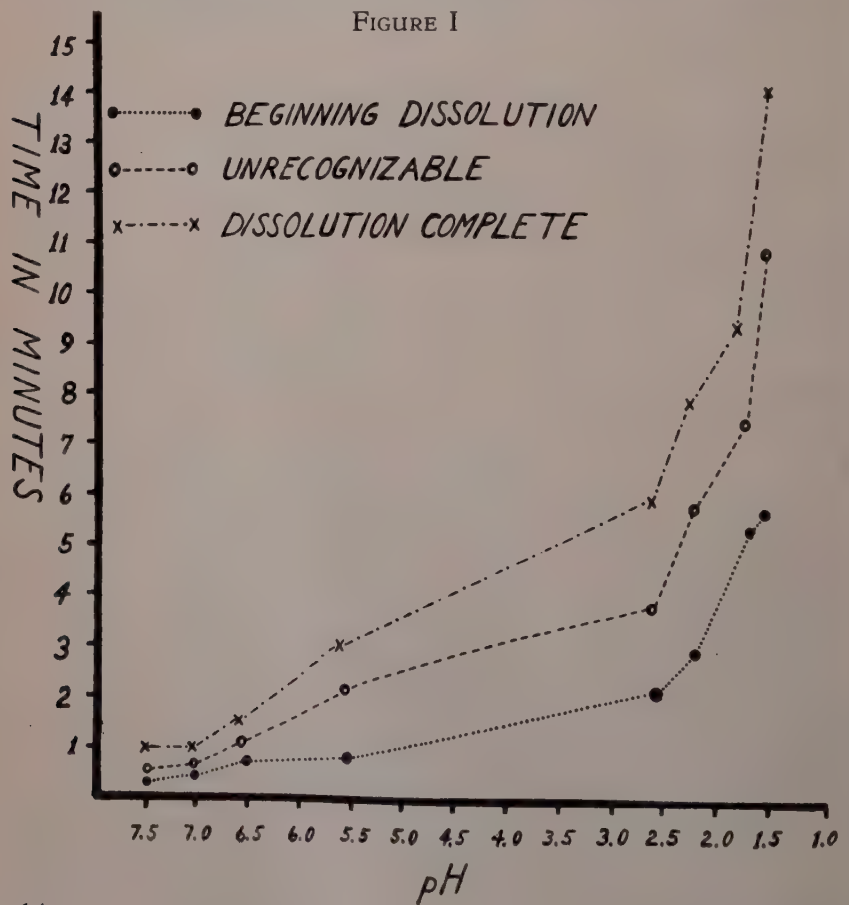
RELATIONSHIP OF pH TO DISSOLUTION TIMES.

Age	Diagnosis	pH	Free Acid	Agitation	TIME Beginning dissolution	TIME Wafer Unrecognizable but not completely dissolved	TIME Complete dissolution
40	duodenal ulcer	7.3	no	10″	15″	30″	1′30″
63	gastric ulcer	1.8	yes	1′	5′30″	6′	7′
53	post-op. subtotal gastrectomy	7.1	no	30″	3′	3′30″	4′
26	post-op. subtotal gastrectomy	7.1	no	none	10″	30″	1′30″
56	post-op. subtotal gastrectomy	5.2	no	none	10″	1′30″	2′
31	post-op. subtotal gastrectomy	5.5	no	none	30″	2′	3′
40	post-op. subtotal gastrectomy	7.0	no	none	10″	30″	1′
64	post-op. subtotal gastrectomy	6.9	no	30″	30″	1′30″	2′
65	post-op. subtotal gastrectomy	6.9	no	30″	30″	2′	2′30″
32	hiatus hernia	1.9	yes	30″	10′	11′	14′
58	bleeding duodenal ulcer	1.7	yes	none	10′	18′	20′
62	post-op. subtotal gastrectomy	5.3	no	none	2′	8′	10′
57	hiatus hernia	1.5	yes	30″	2′	17′	20′
35	post-op. subtotal gastrectomy	3.3	yes	30″	2′	6′	8′
57	post-op. subtotal gastrectomy	7.7	no	30″	2′	8′	10′
64	hiatus hernia	7.4	no	30″	2′	10′	14′
60	hiatus hernia	1.5	yes	30″	18′	21′	..
62	duodenal ulcer	2.75	yes	30″	3′	3′30″	4′
55	hiatus hernia	2.5	yes	30″	13′	15′	..
58	hiatus hernia	6.8	no	none	1′	1′30″	2′
67	gastric ulcer	2.4	yes	30″	2′30″	4′	6′

61	obstructed duodenal ulcer	2.4	yes	30″	3′	4′30″	. .
59	post-op. subtotal gastrectomy	6.7	no	none	15″	30″	1′
58	post-op. subtotal gastrectomy	7.0	no	none	15″	30″	1′
36	post-op. subtotal gastrectomy	5.0	no	none	15″	30″	1′30″
42	post-op. subtotal gastrectomy	6.6	no	none	15″	30″	2′
44	post-op. subtotal gastrectomy	2.1	yes	30″	4′	5′	. .
34	duodenal ulcer	1.9	yes	30″	5′	12′	. .
57	duodenal ulcer	1.5	yes	30″	6′	13′30″	. .
42	duodenal ulcer	1.3	yes	30″	2′	5′	. .
40	duodenal ulcer	2.3	yes	30″	3′	6′	9′
60	gastric ulcer	6.8	no	10″	2′	3′	4′
56	hiatus hernia	7.5	no	10″	2′	3′	4′
55	post-op. subtotal gastrectomy	7.2	no	none	2′30″	3′	3′30″
81	chron. cholecystitis: gastr. ulcer	7.7	no	none	30″	1′30″	2′30″
28	duodenal ulcer	1.8	yes	30″	7′	30′	. .
59	duodenal ulcer	1.6	yes	30″	5′	7′	9′30″
44	bleeding duodenal ulcer	1.5	yes	30″	6′	11′	14′
57	hiatus hernia	3.4	yes	none	1′	2′	3′
47	post-op. subtotal gastrectomy	7.5	no	none	15″	30″	1′
34	post-op. hiatus herniorrhaphy	7.3	no	none	10″	20″	30″
64	duodenal ulcer	6.5	no	none	30″	1′	1′30″
56	gastric ulcer	2.7	yes	none	30″	1′30″	2′
42	duodenal ulcer	1.6	yes	none	1′30″	2′	2′30″
38	pre-pyloric ulcer	2.4	yes	30″	30″	2′	3′
33	post-op. subtotal gastrectomy	6.8	no	15″	30″	1′	2′
67	post-op. subtotal gastrectomy	6.8	no	15″	30″	1′	1′30″
61	duodenal ulcer	1.5	yes	45″	8′	11′	. .
37	post-op. subtotal gastrectomy	3.3	yes	30″	2′30″	4′	5′
38	post-op. subtotal gastrectomy	7.5	no	10″	30″	1′	2′

Method: With the patient in the fasting state the stomach was aspirated by means of a Levin tube. The pH of the recovered specimen was determined with a Beckman electrometric pH-meter. A 5 cc. sample was placed in a water-bath at 37°C. One-quarter of a standard-sized (2.8 cm. diameter) unconsecrated host was mixed with saliva intra-orally and then placed in the sample of gastric juice. Agitation with a wooden spatula for varying periods was occasionally used to simulate the mechanical effect of peristalsis. Three end-points were determined: (a) the time required for beginning dissolution to become apparent; (b) the time required for the host to become unrecognizable as such, but not completely dissolved, and (c) the time required for complete dissolution. These end-points were dependent upon the judgment of the observer ("according to common estimation"), in the absence of a feasible chemical test. All the subjects were male and the age range was from 26 to 81 years. Table I summarizes the results obtained in this study.

FIGURE I



It is evident that rapidity of dissolution varies inversely with the acidity of the specimen, due principally to the inhibition of ptyalin in an acid medium. Several representative determinations illustrating this relationship are presented graphically in Figure I.

Regardless of the pH, in only 9 of the 50 patients did the time required for the wafer to become unrecognizable ("corrupt"), though not completely dissolved, exceed 10 minutes, and in the majority it was considerably less. In these 9 individuals, all of whom showed a low pH, the times ranged from 11 minutes to 21 minutes. It is likely that all of the recorded times would have been shorter if *in vivo* peristalsis could have been more effectively simulated.

CANON LAW AND THEOLOGICAL OPINION

The Code of Canon Law[2] commands that Holy Viaticum for the sick be not unduly postponed, and those who have the care of souls are enjoined to watch with care so that patients may be refreshed with Viaticum while fully in command of their faculties. In many fatal illnesses the hours previous to the moment of death are not conscious ones. Some patients may be irrational or comatose. Others, while conscious, may experience difficulty in swallowing in the hours preceding death because of vomiting or the necessity of employing nasogastric suction.* Thus in such cases there is little possibility of Viaticum being administered in the final minutes of life with death ensuing immediately after swallowing of the Sacred Host. However, there are some types of death which could conceivably occur immediately after the reception of Communion. The incident of a man suffering a fatal coronary occlusion or cerebral vascular accident in or near church after receiving Communion, the execution of a condemned criminal soon after his last Communion, or the sudden death of an accident victim are possible instances in which Communion may have been received within a very short time before death. Should an autopsy be performed promptly there arises the problem that the Sacred Host may not have been digested and may still be incorrupt in the stomach. Digestion is known to continue post mortem since the digestive enzymes already secreted at the time of somatic death retain their potency. The chemical interaction of the enzymes and stomach content does not cease immediately although the declining environmental temperature tends to retard the rate of digestion. The potency of enzymes already secreted at the time of death is readily manifest by autolysis. Most autopsies are performed several hours after death, which would appear to allow sufficient time for the corruption of the Host in the cadaver by the action of the enzymes present.

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[2] Codex Juris Canonici, canon 865, Newman, Westminster, Maryland, 1942. p. 290.

[3] Malboeuf, Rev. Rene P.: personal communication.

* It has been observed[3] that patients with indwelling Levin tubes on constant suction may swallow the Species more readily if the tube is compressed with the fingers during the act of deglutition.

However, it is frequently advisable that necropsy be performed promptly on patients dying of certain diseases, such as brain tumor and blood dyscrasias, especially the leukemias, in order that the histopathology be altered as little as possible by post mortem degeneration. If such an autopsy is performed shortly after death (as may also be done in the case of an executed criminal), there exists the possibility that the Sacred Host is still incorrupt. If the doctor performing the post mortem examination must examine the stomach and finds the Host still recognizable it would seem proper that he take hold of It with forceps, place It in a clean cloth, and request a priest to take It for disposition. In this event the priest would be guided by the prescriptions of the Roman Missal[4] which require that the Host be placed in a holy place until It corrupts. What remains is then to be put into the sacrarium. If the post mortem procedure does not necessitate opening the stomach enzymatic action will dispose of the Host in due time. The time required for digestion and corruption of the Sacred Species is not uniformly estimated by all theologians. (The manuals do not treat of post mortem digestion but merely discuss the length of time that the Species remains incorrupt in the stomach of the communicant.) Merkelbach[5] observes that the common estimate is fifteen minutes although some writers require thirty minutes. This estimate is made of the healthy, for in the sick he says the Species remains several hours or even a day. Canon Durieux[6] states, "A sick stomach sometimes takes two or three hours to digest a small Host." Capellmann[7] thinks a space of a half-hour to be the minimum needed. Cappello[8] cites Gasparri[9] who quotes the opinion of two physicians[10] that a minimum of one-half hour is required for the digestion of a small Host except in the case of the sick. They state that, "Other than the few ulcerous stomachs which may digest a small Host in ten or twenty minutes an afflicted stomach will need two or three hours to act on the small Host."

DISCUSSION

As far as could be determined, the most recent medical estimate regarding the minimum time required for corruption of the ingested Host has been that of George and Core[10] in 1893. These writers agreed on a minimum of one half hour for the digestion or corruption of a small Host by a healthy stomach. They state that "the few ulcerous stomachs" may digest a small Host in 10 or 20 minutes. It is evident that the "ulcerous stomachs" mentioned by

[4] Missale Romanum, Tit. 10, De Defectibus, n. 14., Mame, Turin, 1951. p. 50.

[5] Merkelbach: *Summa Theologiae Moralis,* 2nd ed., (3 vols.), Desclée, Paris, 1936. Vol. III, p. 212.

[6] Durieux: *The Eucharist* (Law and Practice), translated by Dolphin, Donnelly, Chicago, 1926. p. 184.

[7] Capellmann: *Medicina Pastoralis,* 7th ed., Barth, Aachen, 1890. p. 187.

[8] Cappello: *De Sacramentis,* (5 vols.), Marietti, Turin and Rome, 1949—1953. Vol. I, p. 327.

[9] Gasparri: *De Eucharistia,* (2 vols.), Delhome and Briquet, Paris, 1897. Vol. II, pp. 407—408.

[10] George and Core: *L'Universite Catholique,* December, 1893.

the writers must refer to the achlorhydric stomachs of malignant gastric ulcer and not the highly acid stomachs of benign duodenal ulcer.

Since nowhere was encountered an estimate of wafer-digestion based on experimental evidence, the present study was undertaken. The results indicate that corruption of the ingested host may progress at a considerably more rapid rate than heretofore believed, and that, *ceteris paribus,* the pH of the gastric contents is a decisive factor. In general, the speed of dissolution varies inversely with the pH of the gastric secretions. Even in the few subjects whose time of digestion was prolonged, the maximum time for the ingested host to become unrecognizable did not exceed 21 minutes. It would appear, therefore, that the previously accepted values should be revised downward. On a practical plane, it would seem that except in the most unusual circumstances no undue concern about possible desecration of the Sacred Species need be entertained when an autopsy is conducted on a recent communicant. Intractable vomiting would, of course, militate against reception of the Sacrament. However, even a patient requiring nasogastric suction may receive Communion, particularly if there is no medical contraindication to the interruption of suction for a period of 20 to 30 minutes after reception of the Host. The use of a Miller-Abbott tube on constant suction should constitute no deterrent to the reception of the Sacrament if the advancing end of the tube is in or beyond the duodenum. It is almost a certainty that a Host received by an ileostomy patient with severe diarrhea would be corrupted long before It reached the terminal ileum. Apart from mental incompetence, defective sensorium, or intractable vomiting, there appear to be few medical contraindications to the reception of Holy Communion by the ill. In general, it would seem that the Grace to be gained by reception of the Sacrament outweighs any risk of irreverence to the Sacred Species if such irreverence is less than *certain* to follow.

CONCLUSIONS

Experimental data herein presented indicate that the time required for corruption of the ingested host is briefer than previously believed. The rapidity of digestion varies inversely with the pH. Apart from mental incompetence, defective sensorium, or intractable vomiting, there appear to be few medical contraindications to the reception of Holy Communion by the ill. In debatable instances it would seem that the Grace to be gained by reception of the Holy Eucharist outweighs any risk of irreverence if the latter is less than *certain* to follow.

Materia Medica . . . 1155 A. D.

by Francis X. Curley, S.J.

Some eight hundred years ago, when the study of the natural sciences, including medicine, began to flourish in the West, one of the centers of dispersal was the monastery of Chartres. There one William of Conches, (d. 1154), a student of Saint Bernard's, headed a small band of monks in the task of disseminating the "new" learning. They themselves obtained it by studying earlier and contemporary latin translations of the medical and astronomical writings of the Near East, especially Arabia. The physical and physiological lore of the Arabs was known to the ancient world, but for centuries western Europe had been sealed off from this culture and learning.

Salerno, on the Gulf of Naples, was a medical center of sorts from the ninth century, the physicians there drawing on a smattering of Greek medical knowledge which had been preserved in Sicily. Gradually there trickled in from Toledo a series of Jewish savants who brought with them the wisdom of their Arab conquerors. This was laboriously translated by the monks into latin, and thus came into being the great body of Salernican *materia medica,* full of semeticisms which have prevailed up to our own day. (It is interesting to note in our "enlightened" age when women have equal rights, that during the "dark" eleventh century women practised medicine and lectured at Salerno.)

Such work of translating and codifying occupied William and the monks of Chartres. But they were not mere copyists; much that they wrote is their own. Their medical data is deeply dependent on Hippocrates' concept of humours which for so many centuries was the premise for explaining all corporeal activity. While we can smile today at their credulity, the monks displayed that vital inquisitiveness which is the mark of a research scientist. It is noteworthy how facile they were in developing hypotheses, how airily they explained away whatever created difficulties. (See below how William, after telling how beards grow, explains their lack in youngsters.) They were the pioneers of western science whom one with the hindsight of almost a millenium can scoff at, but they accomplished a great work. Europe was to discover, through their introduction and enthusiasm, the realms of the physical, after long preoccupation with the metaphysical. The impetus to scientific research was given by these obscure monks of the twelfth century who reintroduced the East to the West.

In his book *On the Philosophy of the World,* William of Conches has a brief essay "About the Head" which illustrates the sort of work that was done at Chartres. He and his companions were trans-

lators and popularizers; to what extent they believed all that they wrote it is difficult to say, but they must be judged in the light of their times. After all, many a medical absurdity has been uttered since the turn of *this* century. There is unconscious humor in his essay, not a little interest, and a vast deal of ingenuity. With no more ado, William of Conches:[1]

ABOUT THE HEAD

"The head is a sort of spherical substance, about two finger lengths from front to rear. It is round, in order that the brain may the more freely move about within it, and lest, if it were rectangular, the humours might stagnate in the corners and induce corruption. Nerve centers have their seat of operations both in the front and the back; the former govern sense activity, while the latter control voluntary motor activity.

"On the outside is the cranium, to whose skin hair adheres. This is formed by the humours which escape through the pores. Because a dry warm vapor contracts when it comes in contact with the cold outer air, it is changed into a corporeal substance. But other vapors, trying to escape behind it, push it out; then they in turn harden, and thus hair 'grows.' But since it is the nature of heavy objects to fall, the hair curls and tumbles about. At no time in life is there a cessation of this growth of hair because at no time is there a lack of superfluities trying to escape the body. (Fingernails grow in much the same manner; superfluities leave the region of the heart via the fingertips, and there they chill and harden.)

"It is true that beards and chest hair do not appear until a certain age. It is also true that females do not usually have heavy facial hair. This latter curiosity is explained by the fact that men generate a two-fold heat in their bodies, by reason of their hearts and their generative organs, giving rise to beards. But women are too frigid (like the outer air) for much hair to form, (though some, as an exception to nature, are very warm-blooded and hence hairy.) For the same reason *castrati* are beardless. In childhood such a lack can be readily explained by the constriction of the pores, except those on the cranium. Finally, hair differs in color because of the various natural complexions of the pores through which the vapors escape. So much for the head."

WHAT'S YOUR DIAGNOSIS, DOCTOR?

About the year William was born, the great Saint Anselm wrote a letter which contains a very neat little problem for diagnosticians. It will not help the poor patient any now, but what would your answer have been? At the time Anselm was Abbot of the monastery of Bec. A short while before

[1] The writer offers his own translations. William's writings are to be found in Migne's *Patrologia Latina,* CLXXII. Though listed among the works of Honorius of Autun, the *De Philosophia Mundi* is now unanimously attributed to William. (Cf. *Dictionnaire de Theologie Catholique,* 1922, s. v. Honorius; *Enciclopedia Cattolica,* 1951, s. v. Guglielmo di Conches.) For William's acquaintance with Arabic medical learning, cf. Haskins' *Studies in the History of Medieval Science* (Harvard U. Press, 1927, 2nd ed., pp. 91-92.)

he had received into his community a most promising subject, the devout and learned nephew of Lanfranc, Archbishop of Canterbury. Now he must write a delicate and difficult letter to the young man's uncle, reporting that Brother Maurice is in very poor health, so much so that he can scarcely go on in his vocation unless a remedy is forthcoming.[2] Anselm expresses his pleasure at Maurice's holiness, good will, humility, and spirit of prayer; but . . . . . .

". . . for some months now Divine Providence has seen fit to visit him with the great affliction of daily and severe headaches, so much so that he has been shut off from all common-life of the house and has been absolutely forbidden the least bit of study or the briefest meditation."

In the hope that the Archbishop can suggest a remedy, or find a physician who is able to come up with a cure, Anselm then describes the symptoms in detail. "He is almost constantly tormented by a pain that goes in waves through his temples, with a sense of a dull weight behind his forehead (especially if he leans forward at all). Any light or sound is bothersome to him in direct proportion to its strength. Often, especially after he has eaten, his whole face becomes noticeably flushed, and at the same time both head and face grow feverish."

Anselm then notes that it seems to be growing progressively worse. Indeed, during some recent attacks there has been fear for his very life. "A chill seizes his head first, then his breast and whole body, markedly affecting him. Soon his heart labors with excessive palpitation. Together with this all strength leaves his members, and his senses grow faint like those of a man who has lost a vast deal of blood. After he revives somewhat from this state, immediately his whole body becomes hot and ruddy, as if he had been ill of the fever. The headache then increases, accompanied by a strong inclination to vomit, though without the ability. And often, especially if he is chanting in choir, his head is so affected that the whole chapel seems to spin about him."

So much for poor Maurice. Lanfranc and Anselm decide to send him off to the country for a long rest. Some months later there is a sprightly exchange of notes between the two, rejoicing over the young man's recovery; so the story has a happy ending. But no further details of either the malady or the remedy are given. What, eight hundred years later, would you diagnose?

MENDEL TRANSMOGRIFIED

To return to William and some notions taken at random from his treatise, notions that will convey a picture of the generally held beliefs of his time. Women are ungallantly, and with superb masculine aplomb, cited as the single cause of sterility whenever it occurs. When conception does take place, the sex of the future child is wholly determined by the geography of the womb. Because the liver is on the right of the womb, and is an organ replete with richer and warmer blood, the sperm finding its way to

[2] Migne, *P. L.*, CLVIII, 1102-03.

the right section will be better nourished and become a man. But if it is so unfortunate as to go to the left, to the cold section of the womb, then the child will be a girl. (In his thorough way, William adds that if it is in the center, a slight bit to one side or the other, the result, depending on the bias, will be a robust female or a delicate male.) He follows this up with a lengthy bit on the part that the four humours play in the formation of the human embryo, making the whole operation sound rather like a typhoon.

In his essay on digestion (a revolting little gem), William discusses the nature of the stomach and strikes out on his own. "It is asked whether the stomach is of a warm nature." Most say that it is, because otherwise the food that has been eaten could not be "cooked" there and prepared for distribution throughout the body. "We declare, however, that the stomach is by nature cold, and only by accident warm." He argues that its contractive and expansive powers mark it as a "nervous organ," and everyone knows that *they* are cold. But whence comes the heat when it is required? Well, he says, the stomach rests on top of the liver, indeed pretty much wraps around it; on its right is the gall-bladder, and on its left the heart, all of them fashioned of warm dry humours. Wherefore the stomach, cold by nature, is placed in the body much like an iron pot over a fire, and in this way fulfills its function.

Somewhat of a surprise is in store for one who reads what he has to say about dreams, if the reader expects to find the sheerest superstition in the beliefs of this monk of the "dark" ages. "Dreams come from traces of thoughts left in the head, from food and drink, from the weather, from one's state of health, from one's sleeping posture — *and have no significance whatsoever.*"

Let us say farewell to William by quoting a sentence from the preface to his book; it is good advice any time, and especially so in reading the older authors on scientific questions. Reductively it is a call to common charity. "If anything erroneous be found in this book, set it down to human weakness, and do not on that account scorn the rest; neither find fault with what is good on account of the error, nor praise what is wrong because of what is well said."

Medical Advisory Committee to Assist Catholic Hospitals

SOME six months ago the executive board of the Catholic hospital Association authorized the president to appoint a medical advisory committee. The purpose of the committee is to have a representative group of medical men who can present to the officers, the executive board and the Catholic Hospital Association staff the point of view of medical men relating to administration, nursing service, the medical care and other patient services in the hospital. A great deal of assistance is expected in solving medical staff problems, the accreditation of hospitals, and the educational policies to be effected.

The first meeting of this committee was held in October at the central office of the Association in St. Louis. The following who had been asked to serve as members were present: Edward H. Bowdern, M.D., St. Louis, Missouri; Joseph V. Finnegan, M.D., St. Louis, Missouri; Raymond J. Bozzo, M.D., Washington, Missouri; Frederick M. Gillick, M.D., dean, School of Medicine, Creighton University, Omaha, Nebraska; William J. Lahey, M.D., dir., medical education, St. Francis Hospital, Hartford, Connecticut; Louis S. Smith, M.D., pathologist, St. Paul's Hospital, Dallas, Texas; Sister Loretto Marie, R.S.M., administrator, Mercy Hospital, Chicago, Illinois; Rev. John J. Humensky, diocesan director of hospitals, Cleveland, Ohio, and Robert S. Myers, M.D., F.A.C.S., assistant director, American College of Surgeons, Chicago, Illinois.

The agenda included many difficult and very significant problems for Catholic hospitals. More than passing interest should be evoked in reading the report which follows. The issues discussed affect many of our LINACRE QUARTERLY readers in a professional capacity and they might well be encouraged to lend effort to help solve some of them in their spheres of duty. It is with this hope in mind that our editor, Father John J. Flanagan, S.J., executive director of the Catholic Hospital Association, arranged to include the report in this issue of the journal.

EDUCATIONAL PROGRAMS FOR INTERNS

The first topic discussed was education for interns in Catholic hospitals. There was general agreement that hospitals could not solve the problem of inadequate supply of interns but that Catholic hospitals could not expect to receive their share of interns unless the educational programs were strengthened. It was pointed out that speakers and conferences do not make a good educational program. Bedside education under the guidance of staff men who are willing to instruct and supervise must be

effectively organized and integrated into the overall program.

The practice of using interns to write all the histories and to assist all surgeons for the purpose of giving service was criticized by the majority of the committee members; rather, it was recommended that interns be assigned only to men who were capable and willing to teach and that they be responsible for only a limited number of patients so that they can follow them through from the writing of the history to discharge.

Most of the members of the committee favored a rotating internship with a minimum assignment of 15 beds and a maximum of 25.

It was also pointed out that the keeping of good medical records was most important in an educational program and that young physicians should be taught to write records that are medically significant rather than merely complete in a quantitative way. It was also agreed that private patients could and should be used in a teaching program. It was noted that the autopsy rate in Catholic hospitals should be improved because of the value of the autopsy for education and for improved patient care. The following three recommendations are deserving of special mention;

1. Advise hospitals to have a director of medical education; in small hospitals an educational committee would suffice. A qualified pathologist or radiologist might, when necessary, serve as medical education director.
2. The Catholic Hospital Association should encourage hospitals to foster medical education programs; even though it is an expense item, it will contribute to improved medical practice.
3. The Catholic Hospital Association should set up conferences or workshops for medical staff and maintain a consultant service.

RESEARCH

Comment was made on the meager amount of research being done in Catholic hospitals and the small number of Catholic doctors engaged in research. It was thought many hospitals are discouraged because it is the opinion that all research is expensive and demanding in time, space and personnel. It was pointed out that there are two kinds of research, basic and clinical. The former does require extensive laboratories, full-time staff, special equipment and adequate funds. Clinical research is less pretentious and can be carried on even in a small hospital by any specialist or general practitioner. The attitude of medical men and administrators is the most important factor. The desire to inquire and to learn on the part of the doctor and the willingness of the administration to encourage, to cooperate, and to provide facilities and environment are essential.

RECOMMENDATIONS

1. The Catholic Hospital Association should encourage research, indicating a general attitude of approval and at-

tendance at professional meetings.

2. Hospitals should be encouraged to attempt only the type of research adapted to each institution. Community hospitals should be cautious about engaging in expensive research projects.
3. The Catholic Hospital Association should publish the sources of grants for research.
4. Research must originate with doctors, but administration should be alert to encourage and to cooperate with efforts of physicians by giving space and some secretarial assistance.
5. Research for its own sake is dangerous.
6. Promulgate the principle that better patient care will result from:
   a) A review of principles
   b) A good educational program
   c) The research that will be the concomitant result.
7. The Catholic Hospital Association should conduct surveys and collect papers delivered by staff members of Catholic hospitals.
8. In encouraging research and education we are only picking up the tradition characteristic of the Church in earlier times when the better medical schools in Europe were under Catholic auspices and when the greatest progress in scholarship was made by Catholic scholars.
9. Certain areas of research could support the teaching of the Church; e.g., in obstetrics we need research to disprove the accusation that it is dangerous for a mother to go to a Catholic hospital for a delivery.
10. An advisory committee on residencies might be organized to designate subjects for research.
11. Call attention to the package library service of the American College of Surgeons.
12. Gear *Hospital Progress* more to interests of the physician who thinks it solely an administrative organ.
13. Prove that the Catholic Hospital Association is interested in the doctor himself and clinical practice.
14. Explain the Catholic Hospital Association to physicians by a brochure for them.

THE CATHOLIC HOSPITAL AND MEDICAL STAFF ORGANIZATION

The advisory committee felt that medical staff discipline should be left to the staff as much as possible. When the staff fails to exercise its responsibility in promoting good practice and when it fails to correct abuses, then administration has an obligation to act. Medical men resent attempts to "police" them, and religious and lay people should respect the professional prerogatives and responsibilities of the doctors.

The medical audit, it was pointed out, is becoming more widespread

and more important. Good doctors welcome it as a device for promoting better patient care. In discussing the accreditation of hospitals, it was stated that small hospitals can be approved if the medical staff and administration make certain that the required functions are being carried out. Although the five following committees are essential in a well organized staff—executive, credentials, joint conference, tissue, and medical records—a small hospital staff can satisfy requirements by demonstrating that the functions of these five committees are being carried out by one committee or by the staff as a whole.

In large hospitals it is very helpful to rotate members of committees as much as possible so that more members of the staff may become familiar with the functioning and the importance of the committees.

In some instances, administration in Catholic hospitals moves too rapidly and takes drastic action without consulting the medical staff. This statement led to the topic which came up frequently in the deliberations of the committee, the need for better liaison between the medical staff and the governing boards of Catholic hospitals. It was pointed out that the joint conference committee is an excellent device to remedy this situation. It was suggested that the Mother General or Mother Provincial might well be a member of that committee or at least attend a meeting of the committe when she visits the hospital.

There was a feeling that hospital administrators should be careful to seek advice from well qualified and progressive members of the staff rather than from one who is pleasing and popular and diplomatic.

ETHICAL STANDARDS

A fear was expressed that some Catholic hospitals are concerned only in preventing abortions and sterilizations and do not realize the ethical and moral implications involved in ghost surgery and the unnecessary removal of organs. It was felt that hospitals should be advised regarding the morality involved in ghost surgery, unnecessary surgery and fee splitting.

It was recommended that the individual hospital require that those who participate in consultation sign as consultant and that when a surgeon performs an operation on recommendation of the attending physician, the surgeon be introduced to the patient and his function explained. It is also recommended that the latest amendment of the A.M.A. code be publicized among all hospitals.

THE GENERAL PRACTITIONER

Discussion revealed that an increasing number of people prefer the services of the general practitioner. However, in some sections of the country the general practitioners have difficulty receiving appointments to the staff of hospitals. In large staffs, the general practitioner seems to be overlooked and gets least consideration.

Representatives of the staff of the Catholic Hospital Association informed the committee that the members of the Association were on record through a convention

resolution recommending that all Catholic hospitals make provisions for a general practice section in staff organization. It was also pointed out that the model by-laws suggested by the Catholic Hospital Association include provision for a general practice section.

The committee recommended that an annual review be made of medical staffs with a view to eliminating those who do not avail themselves of privileges and thus make a place for those who are more worthy, including qualified general practitioners. Most general practitioners realize that merit should determine a physician's status on a staff.

The committee hoped that people could be educated to consult a family physician who will refer them to a specialist if necessary. A fear was expressed that some specialists are attempting to act as general practitioners and that this could be a medical hazard. The increasing number of specialists is such that doctors do not wish to make house calls, and if a specialist does make a house call, the fee is usually $25.00.

The committee concluded that discussion by stating that hospitals and doctors have a responsibility to see that the general practitioner is encouraged and recognized in the all-important capacity of a family physician.

NURSING

The committee recognized that there is a shortage of graduate Nurses' salaries have not kept pace with other salaries. The members of the Committee felt that there are too many instances of inadequate care, of carelessness and errors. However, it was admitted that the attitude of nurses parallels the attitude of the doctor. Nurses do not write good notes, because the doctors are not faithful in keeping up charts and nurses become careless because doctors do not take time to read notes or to supervise and check on the nurses' work.

SPIRIT OF CHARITY

The members of the committee were asked to comment on the spirit of charity in Catholic hospitals. They expressed a conviction that the spirit of charity does prevail, but that the public does not realize it. It was pointed out that no mathematical amount can be set for charity. In times of financial depression, the need for charity is greater and the need will vary from community to community.

Dysmenorrhea and Stilbestrol

by JOHN J. LYNCH, S.J.

AMONG generally accepted procedures in the management of primary dysmenorrhea, the administration of estrogen receives rather frequent mention in medical literature.[1] The calculated effect of this hormone, commonly prescribed in the form of diethylstilbestrol tablets, is to achieve painless menstruation through temporary suspension of the ovarian function, since usually "primary dysmenorrhea does not occur in the absence of ovulation."[2] If it is true that one effect of the medication is to inhibit ovulation, and that it is only through the attainment of this first result that painless flow is achieved, then immediately a question can arise regarding the lawfulness of the temporary sterility which necessarily occurs. It may in fact appear at first sight that the use of stilbestrol would have to be condemned for the very reasons which have been adduced against hesperidin as an antifertility factor.[3]

There is, however, a distinct and important difference between fertility control as previously discussed and estrogen therapy in the present instance. First of all, it is clear that the natural function of the ovaries is at least two-fold, generative and endocrine. Hence whenever ovarian activity is suspended, two immediate results are necessarily produced: the subject is rendered sterile, temporarily at least; and the system is deprived of certain glandular secretions which are usually beneficial, but sometimes harmful, to bodily health. Now it is entirely conceivable that either one of those results could be desired and intended without the other. One might, for example, intend sterility while disclaiming completely any deliberate intent to affect secondary sex characteristics. Or, by the same token, one might be intent on preventing metastasis of breast carcinoma and repudiate all direct intention to bring about sterility. Of those two examples involving the same morally indifferent act (suspension of ovarian activity), we recognize the first as illicit and the second as potentially permissible, since in the one case the *direct intention* is illicit, whereas in the other all *direct* intent is legitimate.

And that is why we condemn fertility control as commonly understood. There the directly intended object of medication is sterility itself, and any other possible consequences are incidental by-products as far as subjective intention is concerned. Since the

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[1] Greenhill, J. P., *Year Book of Obstetrics & Gynecology,* 1953-1954 Series, 512-515.

[2] *Ibid.,* 513 f.

[3] Cf. *Linacre Quarterly,* Aug. 1953, 83-88, and Nov. 1953, 118-122. In these articles fertility control is shown to be morally objectionable on two counts: (a) as an unjustified mutilation of the human generative function, and (b) as a species of contraception.

natural law prohibition against *direct* sterilization of this kind is universal, there can be no dispute about the immorality of deliberate fertility control.

But in the management of dysmenorrhea, it is relief from pain which is sought—pain which can be controlled, it seems, by controlling the endocrine activity of the ovaries. Subsequent temporary sterility can now be considered as the incidental by-product of ovarian suppression, whose only directly intended effect is to achieve painless menstruation. And hence we have here a possible application of the principle of double effect.

Before concluding, however, that stilbestrol is morally permissible medication for dysmenorrhea, a certain number of medical questions would have to be answered in such a way as to establish some real necessity for using this procedure in preference to others which do not affect fertility. One of the postulates of the principle of double effect is that there be proportionately grave reason for even permitting an evil result. And such a reason would be lacking if it could be shown, for instance, that painless menstruation could just as conveniently and just as effectively be achieved by a method which would not involve temporary sterility, or if it could be established that relief from pain is not of itself important enough to compensate for the extent of the evil permitted. Since the ultimate decision requires medical experience combined with moral judgment, both physician and theologian have a share of responsibility in determining proper procedure.

VARIOUS MEDICAL PROCEDURES

Judging from available literature on the subject of dysmenorrhea, and from the testimony of physicians consulted personally, there would appear to be no universal medical rule either recommending or discouraging stilbestrol for all cases indiscriminately. Although consideration is given to a number of possible treatments, general consensus seems to be that none is entirely without its disadvantages.

Drug therapy may prove satisfactory, especially in milder cases; but my impression is that it is frequently useless, always labors under the handicap of obliterating only the symptom without correcting the cause, and cannot completely escape the risk of addiction if recourse must be had to the more powerful but habit-forming drugs such as codeine. (Even though the prescribed monthly dosage of codeine should create no more than a negligible danger of habituation, doctors are instinctively reluctant to prescribe a regimen of such drugs if it can be reasonably avoided.)

Hormones, of which stilbestrol is but one species, represent another possible solution. On the theory that menstrual pain is sometimes caused by uterine spasms, progesterone is employed at times since it tends to relax the uterus. Greenhill, however, alleges that it is seldom successful and is comparatively costly. Methyltestosterone, a male hormone, is likewise rated as relatively expensive, and

may also in some cases affect secondary sex characteristics, though it does apparently have the advantage of not suppressing ovulation. And regarding less costly stilbestrol, which occasioned this whole discussion, it is said that pain is relieved in a large proportion of cases, but that relief is by no means permanent and that often either the menstrual cycle is upset or profuse menstruation results. Its chief disadvantage, even medically, is the sterility which it induces—and in proportion to the frequency with which treatment must be repeated, sterility becomes progressively less a temporary state of affairs and verges on permanency.

Surgery appears to be considered a procedure of last resort. Presacral neurectomy is rather commonly mentioned as sometimes successful and as recommended in selected cases after other means of effective relief have been excluded.[4] Dilatation and curettage is another possibility. Doyle favors paracervical denervation through culdotomy, and proposes this method as highly effective in affording permanent relief when surgery is indicated.[5]

It is not my purpose, nor is it within my competence, to judge the relative medical merits of these various procedures. That remains the prerogative of doctors, and even they may have legitimate grounds for disagreement to some extent on that question. But in choosing a procedure which involves temporary sterility, indirectly intended though it be, a physician would have to satisfy himself that there is legitimate medical reason for rejecting other methods which do not affect fertility. It may well be that other treatments are recognized as useless in a given case, or at least considerably less effective than stilbestrol. Comparative expense is another item to be considered, as would be surgical risk or inconvenience to whatever extent they may be envisioned. In general, any serious disadvantage to the patient, which would result either from failure to treat or from the choice of an alternate therapy, will contribute towards establishing reason sufficient for permitting the mutilating effect of temporary sterility as produced by estrogen treatment.

PAIN RELIEF AS A JUSTIFYING CAUSE

Let us suppose that in the considered judgment of a capable physician there is good medical reason (in the sense just explained) for preferring estrogens to other possible treatments. Does pain relief alone constitute reason sufficiently serious to justify temporary sterility as the indirect but inevitable result of inducing anovulatory menstruation via stilbestrol?

First of all it should be conceded —and physicians would doubtlessly be the last to disagree — that pain of itself is not to be dismissed lightly as something necessarily inconsiderable in the order of phy-

[4] For some comments on the moral aspects of presacral neurectomy, cf. Gerald Kelly, S.J., *Medico-Moral Problems,* V, 40. The same article also appeared in *Hospital Progress,* Feb. 1954, 66.

[5] Doyle, J. B., "Uterine Denervation By Culdotomy," *Irish J. Med. Sc.,* Feb. 1953, 73-76; "Use of the Pelviscope in Culdotomy," *J. A. M. A.,* 151: 605-608 (Feb. 21) 1953.

sical inconvenience or hardship. Pain relief can be the moral justification for the medical use of narcotics, sometimes even at the risk of possible addiction or at least to the point of temporary privation of one's rational faculties. Some theologians have also admitted the lawfulness of prefrontal lobotomy in certain cases, exclusively for the purpose of relieving otherwise intractable pain, and they do so with full realization of the other possible effects of that species of mutilation.[6] The immediate point I wish to make is that moralists do allow, for the sole purpose of pain relief, procedures which have very serious mutilating effects on the very highest of human faculties.

It is unquestionably true that in the examples just cited one is dealing with pain so severe that it is commonly termed intolerable; whereas the suffering proper to dysmenorrhea may not ordinarily deserve that classification in the objective order of things. That point can be conceded, it seems, without detriment to the conclusion eventually to be offered in the present discussion. The fact is that we are now dealing with a type of pain which, though varying in intensity from one case to another, can correctly be called severe in many of the cases which find their way to a doctor's office. Even though it may not be objectively comparable to the pain alleged in justification of lobotomy or the use of dangerous narcotics, it is still not to be dismissed as trivial.

Furthermore, any attempt to appraise pain in the objective order alone would be as unreal as it is inadequate. The truth of the matter is that pain is a highly subjective phenomenon whose severity must be measured also in terms of the victim's individual perception of it and reaction to it. The common medical term "threshold of pain" recognizes that subjective and variable element as something inescapably real and essential in measuring gradations of pain. What one person can bear with equanimity may prove excruciating for another.

Besides, how great is average human capacity for tranquil suffering? Persistent pain over a notable period of time—even pain considerably less than excruciating —can be a severe test of almost anyone's powers of endurance; and measured even in terms of minutes, time can assume gigantic proportions in the mind of one who is suffering without prospect of relief. Even the common head-ache or tooth-ache, or the pangs of indigestion, can make release from pain seem the *summum bonum* of the moment for most of us, and very soon find us turning to our favorite nostrums for relief. No realist can deny that placidity in the grip of continued pain reflects either crass stoicism or virtue of more than ordinary dimensions, and is not the sort of reaction usually encountered.

And even if asceticism should prevail over physical distress, it is the rare person even among the virtuous who can long endure without betraying marked loss of

[6] Cf. G. Kelly, S.J., "Lobotomy for Pain Relief," *Medico-Moral Problems*, III, 29-32.

efficiency, power to concentrate, ability to do his ordinary work, capacity to cope satisfactorily with the normal routine of living. All of these disabilities, not to mention the ordinary effects of prolonged pain on one's natural disposition, can constitute a serious handicap for the average individual—serious enough, it would seem, to merit careful consideration when sufficient cause is being sought to justify certain undesirable but concomitant effects of therapy.

In trying to estimate, therefore, the gravity of pain associated with any physical affliction, one should take into account not only the objective nature and measure of the pain involved, but also the subjective and no less real element of individual susceptibility to suffering, especially of a persistent kind. Furthermore, if a patient finds that pain constitutes a real handicap in the normal routine of daily living, that measure of inconvenience cannot properly be termed slight. All things considered, it does not seem unreasonable to propose that relief from pain in many such circumstances can qualify as serious in the category of justifying causes.

Is it serious enough to warrant temporary sterility as a concomitant indirect effect? I am inclined to say that it can be. Moralists admit that even permanent sterility may be permitted when it is the necessary indirect result of therapy required to prevent metastasis, and their teaching on that score has been confirmed by Pius XII.[7] It is true that they are then thinking in terms of preserving, or at least markedly prolonging, life itself, and are not primarily concerned with relief from pain which, relative to life and death, is unquestionably of less importance. But it is also true that the evil they permit in that case (*permanent* sterility) is almost immeasurably greater than the temporary effect involved here, and that a proportionately less serious cause would therefore suffice to justify the latter. Relief from pain would seem to be a serious cause in that legitimate sense of the word, i.e. *sufficiently* serious in view of the *temporary* nature of the evil permitted.

It goes without saying, of course, that stilbestrol should not be employed if some other procedure, which does not affect fertility, can be used as effectively and as conveniently in a given instance. In addition, neither patient nor doctor could legitimately intend contraception as another effect of the medication. But with these precautions stipulated, there would seem to be good reason to allow a physician to prescribe stilbestrol for dysmenorrhea if and when in his considered opinion it is indicated as a reasonably necessary medical procedure.

[7] Allocution to the 26th Annual Convention of the Italian Society of Urologists, Oct. 1953. For the pertinent excerpt from this address, together with comments by Fr. Kelly, S.J., cf. *Linacre Quarterly*, Nov. 1953, 106-107. Cf. also G. Kelly, S.J., *Medico-Moral Problems*, I, 21-29.

The South - Host to Annual Meeting Executive Board

Federation of Catholic Physicians' Guilds

THE WINTER MEETING of the Executive Board of The Federation of Catholic Physicians' Guilds was held in New Orleans, Louisiana, November 27, 1954, at the Jung Hotel. The following were present:

J. J. Toland, Jr., M.D., President also representing Philadelphia Guild
N. F. Thiberge, M.D., Honorary President
Wm. J. Egan, M.D., 2nd Vice President also representing Boston Guild
Rt. Rev. Msgr. D. A. McGowan, Moderator
Wm. E. Barker, Jr., M.D., Baton Rouge Guild
E. J. Murphy, M.D., Bronx Guild
L. B. Zeis, M.D., Houston Guild
J. O. Muscat, M.D., Mobile Guild
Rev. P. H. Yancey, S.J., Mobile Guild
Ruth G. Aleman, M.D., New Orleans Guild
J. Menville, M.D., New Orleans Guild
Very Rev. Thomas Bolduc, S.M., New Orleans Guild
Alice Holoubek, M.D., Shreveport Guild
Rev. J. J. Flanagan, S.J., Editor, THE LINACRE QUARTERLY
M. R. Kneifl, Executive Secretary
Jean Read, Assistant Secretary

* * *

Dr. Toland called the meeting to order at 9:30 a.m.

DUBLIN CONGRESS OF CATHOLIC PHYSICIANS

Msgr. McGowan reported on the Sixth International Congress of Catholic doctors, recognized by the Holy See, held in Dublin, Ireland, June 30-July 4, 1954. He advised that the Americans present would have preferred more scientific papers than were given. The hosts for the Congress spared no efforts to make the visit of the delegates most enjoyable. The next meeting is scheduled for Amsterdam, Holland, probably in 1957. (See account Nov. 1954 *LQ*, pp. 132.)

LINACRE QUARTERLY

The report concerning circulation of LINACRE QUARTERLY was given by Jean Read who advised that subscriptions total approximately 5,700 of which 2,900 are for Guild members. Quantities of student subscriptions are financed by the following Guilds: Boston, Bronx, Cleveland, Houston, Minneapolis and St. Louis. Other subscribers are doctors who are not Guild members, priests, hospitals, libraries and others interested in the medical field.

Father Flanagan, giving the Editor's report, presented a list of topics for consideration. Some 34 subjects were included; a variety of titles such as "Experiences with Telepathy," "The Physician is also a Father," "The Value of the Medical Audit," "Does the Tissue Committee have a Moral Value?" "The Role of the Catholic Doctor

in Medical Education" were a few of the suggestions. The list of suggested topics was reviewed and discussed and many helpful suggestions made to the editor.

Membership Report

The membership report indicated a total of 38 Guilds, 36 of which are affiliated with the Federation. The Guilds added to membership since last December number ten. Prospective Guilds include the following to be contacted for affiliation: Westchester, New York; Pittsburgh, Pottsville and Chester, Pennsylvania; Newark, New Jersey; Tacoma, Washington; Worcester, Massachusetts; Burlington, Vermont; Seattle, Washington; and Toledo, Ohio.

The visit of Archbishop Rummel

At this point of the meeting, The Most Reverend Joseph F. Rummel, Archbishop of New Orleans, joined the group. His Excellency welcomed the Executive Board to New Orleans and graciously spoke to the members.

Having sponsored the organization of his city's Guild, the Archbishop was very enthusiastic about this work stating that the Catholic members of the medical profession are becoming more and more important as time goes along. "They stand isolated and alone," he said, "because of high principles in a materialistic world that has discarded all spiritual and moral values and responsibilities. It is the body, only, that matters to those who disregard definite natural and supernatural laws which should be observed." The Archbishop further emphasized that Catholic doctors must become vocal in espousing supernatural principles. Proceeding further he stated: "The mission of the Catholic physician has apostolic spirit. His superior training should make him aware of his responsibility and duties and his influence on fellow-physicians. He must express himself when opposing points of view are presented, not only to refute conclusions but be able to explain the basis for them. He must present convincing arguments to offset damaging opinions."

Financial Report—1954

Mr. M. R. Kneifl, executive secretary, then discussed the financial report. This was the first year for which an actual budget had been set up which resulted in some disparity that is being provided for in the 1955 budget. It can be happily reported that the financial advances made by The Catholic Hospital Association to assist the Federation of Catholic Physicians' Guilds in its operations have been fully liquidated. A word of thanks was expressed for this help.

Total income for the year 1954 (the last two months being estimated) exceeded the budget by $1,352.00. Expenditures exceeded the budget by $1,546.00 due to the fact that printing costs on Linacre Quarterly were in excess of the budget figure and several items of expense were unusually high during the year.

Executive Board Meetings

Discussion then concerned future meetings of the Executive Board. The June meeting will be

held in Atlantic City, New Jersey as it is always convened in conjunction with the A.M.A. Convention which will be held there in 1955. It was voted to have the winter meeting in St. Louis.

St. Luke's Day Observance

The observance of the St. Luke's Day Mass is becoming more and more widespread; for that reason it was deemed time to assign a special designation to the ceremony. Dr. Muscat stated that since white prevails for the garb of the doctor, he would suggest the "White Mass." Discussion followed and the vote taken favored this name. The Feast of St. Luke, patron of Catholic physicians, is October 18 and since it is movable, this Mass is usually set for the Sunday closest to that date. With this special designation, henceforth, it was felt that promotion of its observance will be further stimulated.

Publicity

As an item for the future, radio and television programs were considered. When a series can be prepared concerning the Catholic doctor and his influence in medical and allied fields, time will be secured on these communication media.

Medical Newspaper Features

Feature articles in Catholic and secular papers were discussed with special reference to those furnished *The Pilot* in Boston by members of the Guild of St. Luke in that city. Brief but concise answers to medical problems were presented in this series appearing weekly; when editorial material lagged, the project was discontinued but will be resumed early next year. Other Guilds were encouraged to do likewise in their local newspapers to combat erroneous material often involving moral issues.

Programs on Medical Ethics

Many Guilds are located in cities where there are medical schools. It was suggested that these groups investigate medical ethics programs offered and if not adequate, to provide instruction and opportunity for discussion. It was advocated that Catholic clubs in non-Catholic medical schools be organized. Those at Tufts, Harvard, and Boston University were cited as examples. It was recommended that the *Medico-Moral Problems* series by Father Gerald Kelly, S.J. be furnished all medical school libraries.

Institutes on Medico-Moral Problems

A project for consideration by individual Guilds was listed on the agenda as "Institutes on Medico-Moral Problems." They are highly successful in many parts of the country in the hospital field. Doctors, priests, sisters engaged in hospital work, nurses and others take part in the sessions. They could well be sponsored by Guilds, was the general opinion. The Catholic Hospital Association has been assisting in the promotion of these meetings and could give advice on their conduct.

This Year's Goal

Discussion of special projects for the Federation to sponsor during the next year resulted in the fol-

lowing—in the order listed:

Promote the "White Mass."

Sponsor formation of new Guilds.

Sponsor Junior Guilds in medical schools.

Take some means to dispel belief that in Catholic hospitals mothers' lives are sacrificed in favor of new-born; this and other antiquated ideas do untold harm to the reputation of Catholic institutions.

GUILD REPORTS

Guild representatives reported on their respective activities.

Dr. Eusebius Murphy reported for the Bronx Guild. He advised that three meetings are held yearly. Members of the Guild staff St. Patrick's Home for the Aged, long in need of special help in this regard. Contact is made with third year college students to interest them in medical careers. LINACRE QUARTERLY is furnished in quantity at the Guild's expense to senior medical students at such schools in New York City. Members make a closed retreat in March. Speakers are furnished from the ranks of the Guild for the Marriage Forums that are conducted in New York. The Bronx Guild through promotional efforts was greatly responsible for the formation of the Guild in Westchester, New York.

Dr. L. B. Zeis reported for the Houston Guild. A Mass and Communion breakfast are part of this group's activities. A series of six lectures on medico-moral problems has been sponsored; medical students from Baylor College in Houston were invited to attend. Another series will be conducted next year. A closed retreat was also provided for the members during the year.

Dr. Wm. J. Egan reported for the Guild of St. Luke in Boston and advised that his group had sponsored a Marian Year Mass to which civic leaders were invited. A new project for the Guild is a series of round table discussions. Groups are comprised of no more than 12 persons, who in turn organize other units. Meetings are held in the homes of the members. This Guild also lends invaluable support to the Catholic clubs in non-Catholic medical schools.

Dr. Ruth G. Aleman advised that the New Orleans Guild has four meetings during the year. Guest speakers are invited and there is a Communion breakfast. Members make a retreat. The Guild provides for physical examination of children in Catholic schools. A special committee provides reading material for medical schools. This group also lends support to the Newman Club.

Dr. Barker, speaking for the Baton Rouge Guild, indicated that four meetings are held yearly for their group: one social, a Communion breakfast, a St. Luke's Supper, and a dinner meeting to which all obstetricians and gynecologists in the area are invited. A speaker with a pertinent subject is invited for the occasion. An objective of the Baton Rouge Guild is to organize other Guilds in the diocese.

Dr. Muscat, reporting for Mobile, advised that a Mass and Communion breakfast represent the activity of that group thus far.

(This is one of the most recent Guilds to be formed.)

Dr. Alice Holoubek from the Shreveport Guild advised that all the Catholic doctors in that city are members of the Guild. This group, like Mobile, is newly organized. Small groups have been formed for discussion; non-Catholic friends are included. At present the book "Image of His Maker" is being discussed.

NEW BUSINESS

The Board unanimously recommended the reinstatement of the Belleville (Illinois) Guild in the Federation.

The Board authorized a monthly bulletin with news items for the Guilds for the months when THE LINACRE QUARTERLY is not published.

The Board suggested that the editors list in THE LINACRE QUARTERLY, from time to time, localities where Catholic doctors are needed. There is a shortage in many areas and information regarding situations would be of interest to physicians desiring to make changes for various reasons. The Catholic Hospital Association can furnish this information.

The meeting adjourned at 4:30 p. m.

Members of the Executive Board were guests of the New Orleans Guild at a dinner meeting in the Jung Hotel.

In the News....

Test-tube babies and divorce

An important ruling clarifying moral and legal problems arising in a recent divorce case was featured with great emphasis in *The New World*, Chicago Catholic weekly. Superior Court Judge Gibson E. Gorman ruled that "Test-tube babies are illegitimate if the natural fathers were not the donors. Mothers guilty of such practices have committed adultery, even if the artificial insemination was performed with the consent of the husband," he decreed. The judge rendered the decision in a divorce suit in which a mother made the claim that her five-year-old son was born as a result of artificial insemination. She claimed that as a result of this, the child is the child of the mother alone and that the husband has no right or interest in the boy. In her divorce suit she accused her husband of "habitual drunkenness."

The husband's opposing petition contended that he is actually the father of the child. But it said that if the woman was artificially inseminated, then it was "without sanction of moral or natural law, and without regard for the future rights" of the child and constituted an act of adultery.

In his ruling, Judge Gorman made judgment on the following propositions which he had been asked to affirm:

—Artificial insemination is not contrary to public policy.

—Artificial insemination does not constitute adultery.

—A child born of artificial insemination is legitimate and the child of the mother only; the father or husband has no right to said child.

Judge Gorman decreed:

"1. *Heterologous* artificial insemination (when the donor is a third party) with or without the consent of the husband, is contrary to public policy and good morals, and constitutes adultery on the part of the mother. A child so conceived is not a child born in wedlock and is therefore illegitimate. As such, it is the child of the mother, and the father has no right or interest in said child.

2. *Homologous* artificial insemination (when the donor is the husband of the woman) is not contrary to public policy and good morals, and does not present any difficulty from the legal point of view."

The answering petition asserted: "The alleged artificial insemination is immoral because both natural and divine law establish the fact that a new life must be procreated only inside marriage. The voluntary surrender by the plaintiff to another person of her reproductive powers or faculties should be held by the court to be an act of adultery."

Attorney for the defendant was expected to file a complaint with

the American Medical Association accusing the physician of malpractice and unethical practice.

Judge Gorman, who is a Catholic, said the attitude of the Church on artificial insemination had no effect on his decision. He declared: "This was strictly a legal decision covering the particular issues at hand. It was not affected by moral principles of my own."

In the wake of the ruling on the illegitimacy of test-tube babies, Chicago doctors have urged the A.M.A. to fight the decision. Obstetricians and gynecologists there, however, said that so long as the decision holds, they will handle no further artificial insemination cases.

It was recalled that in 1949 His Holiness Pope Pius XII declared artificial insemination to be a gravely immoral violation of the marriage bond.

LINACRE QUARTERLY has published several articles on the subject.

New medical school

The establishment of New Jersey's first medical and dental school with opening set for September 1955 was announced in mid-December. The Clinical Building of the Jersey City Medical Center will house the new Seton Hall College of Medicine and Dentistry. Seton Hall, a Catholic university, has signed a 50-year lease for the building.

The state had been approached to take over a portion if not all of the hospital that is operated by the Jersey City Medical Center but the offer had been declined. In signing the pact, Archbishop Boland declared: "We are not entering with an illusion that this will be a profit making venture . . . it is a sacrifice for the greater common good." He declared that the school will be operated for the "best interest of all people of our state."

There are still agreements to be reached regarding the future operation of the hospital.

It is interesting to note that the first college of medicine and dentistry in the state will be added to the five other schools of this kind conducted by Catholic universities in other parts of the country.

Medical profession and specialization

"The medical profession is suffering from over-specialization," Dr. Daniel L. Sexton, vice-president of the Federation of Catholic Physicians' Guilds and newly installed president of the St. Louis Medical Society, declared in his inaugural address. "Today we are finding our profession over-specialized and suffering from lack of practitioners with broad training who can treat most of the prevailing ailments," Dr. Sexton stated.

"This past year more medical graduates are inquiring about rotating internships and are seeking training in those hospitals offering such services," he said, "And this is a healthy sign indicating the pendulum is swinging away from specialization." Dr. Sexton echoes much of the thought expressed by the medical advisory committee assisting our Catholic hospitals.